Division of Children and Youth With Special Health Care Needs (CYSHCN) Program

CYSHCN ORTHODONTIC SERVICES REQUEST FORM

ORTHODONTIST

Name _____

Mailing Address _____

Phone Number _____

APPLICANT

Last Name _____ First Name _____ Date of Birth _____

Parent/Guardian Name _____

Mailing Address _____

Daytime Phone _____

SCREENING QUESTIONS To be completed by licensed orthodontist. Record all measurements in order with teeth in centric position. Round to nearest millimeter.

1. Class II OVERJET in millimeters (positive numbers only), measured from facial lower incisor to facial upper incisor _____ mm x 3 = _____
2. OVERBITE in millimeters (positive numbers only), measured from upper incisal edge to lower incisal edge _____ mm x 2 = _____
3. Class III REVERSE or NEGATIVE OVERJET in millimeters measured from facial upper incisor to facial lower incisor _____ mm x 5 = _____
4. ANTERIOR OPEN BITE in millimeters measured from incisal edge to incisal edge _____ mm x 4 = _____
5. Number of radiographically documented IMPACTED TEETH *excluding* 3rd molars, crowded and/or blocked out teeth (PANOREX required) _____ teeth x 5 = _____

6a. Number of arches with MODERATE CROWDING (< 6 millimeters) _____ arches x 2 = _____

6b. Number of arches with SEVERE CROWDING (>6 millimeters) _____ arches x 4 = _____

7a. Number of upper permanent teeth in ANTERIOR CROSS BITE _____

7b. Number of upper permanent teeth in POSTERIOR CROSS BITE _____

8. Number of habits affecting arch development (describe below) X 2 = _____

TOTAL SCORE _____

*Minimum qualifying screening score is **35** points.*

Exceptions made for children with medically documented cranio-facial anomalies including:

- *Cleft lip or palate;*
- *Pierre-Robin sequence;*
- *Hemifacial or craniofacial microsomia;*
- *Crouzon, Apert, or Treacher-Collins syndrome; and*
- *Condylar aplasia.*

DENTITION ☐ Transitional ☐ Adolescent

DOCUMENTATION ATTACHED (Photos and cephalogram required)

☐ Cephalogram (must be original image with embedded scale or notation of image scale.)

☐ Panorex (required for impacted teeth) ☐ Photographs (high quality facial and intra-oral)

REQUEST ☐ Interceptive Treatment ☐ Comprehensive treatment ☐ Continued Treatment (for transfer cases)

SCREENING ORTHODONTIST COMMENTS

SCREENING ORTHODONTIST SIGNATURE _____ Date _____

RETURN COMPLETED FORM TO REGIONAL CYSHCN OFFICE OR CALL 803-898-0784 FOR ASSISTANCE

DHEC USE ONLY

☐ **DOES NOT MEET** clinical requirements for orthodontic services ☐ Approved for Interceptive treatment only

COMMENTS ☐ Approved for Comprehensive treatment only

CYSHCN Orthodontic Consultant Signature	*Date*	*CYSHCN Program Office Signature*	*Date*

Label

INSTRUCTIONS

TITLE

Children and Youth with Special Health Care Needs (CYSHCN) Program Orthodontic Services Request Form (DHEC 0762)

PURPOSE

This form is used by licensed orthodontists and DHEC staff to submit information necessary to determine clinical eligibility for CYSHCN orthodontic services.

ITEM-by-ITEM INSTRUCTIONS

1. Orthodontist information: Enter name of referring orthodontist enters name, phone number, and mailing address (this is address to be used for provider correspondence).
2. Patient information:
    a. Enter name and date of birth of the person to receive orthodontic services.
    b. Enter name, address and phone number of parent or guardian.
3. Screening questions, documentation, requested services and comments completed by referring orthodontist, who will sign and date the form before submitting to DHEC.
4. CYSHCN Program staff or consultants will complete “DHEC USE ONLY” section in accordance with applicable policies by checking appropriate boxes, signing and dating the form.
5. Copies of completed form are sent to submitting orthodontist, and submitting regional CYSHCN office.

OFFICE MECHANICS AND FILING

This form should be filed in the comprehensive health record according to the Health Record Format located in the Health Record Policy Manual. The comprehensive health record retention schedule applies.

The completed form is filed on the left side of the health care record behind the “Correspondence/Other tabbed divider in chronological order, most recent on top. Retention schedule and destruction same as for DHEC Health Records.